Psychiatric contributions to the undergraduate medical curriculum

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The contribution of psychopathology to disease in terms of predisposing, precipitating and perpetuating factors, and the expressions of mental illnesses themselves, are recognised as widespread and commonplace in the population; so are the 'psychiatric' consequences of 'physical' disease. It is a challenging task to bring order to the matter and to render it acceptable in the minds of medical students, and especially important for that 50% of them who are going to be GPs. It is equally important that the 5% of them that choose to become psychiatrists is the right 5%!

Within medicine, psychiatry is seen as a specialist subject, especially insofar as it deals with psychosis and other severe mental illness. Accordingly, it is often taught in medical schools alongside other so-called specialist subjects such as paediatrics and obstetrics and gynaecology. These are seen to contrast to generalist subjects such as medicine and surgery, but which themselves are usually taught within the framework of highly specialised firms concentrating on one or two organs or systems within the body.

Within psychiatry there are specialist areas of practice. Some of these are recognised formally by our College and by the health service, e.g. child and adolescent psychiatry, psychiatry of addictive behaviour, psychiatry of learning disability, and forensic psychiatry. Others are less generally recognised and are more likely to be the consequence of idiosyncratic service or research developments, e.g. disorders of eating, sleeping and sexual function, neuropsychiatry, and puerperal disorders. This applies also to certain treatment approaches. For instance, milieu therapy and behavioural psychotherapy are less universally developed in psychiatric practice within the health service than is dynamic psychotherapy. Paradoxically it is some such categories of highly specialist practice which reflect more commonplace disorders within the general population.

Psychiatric teaching to undergraduates often focuses on the major illnesses and their treatment and management. All students clearly need to know how to identify the major psychoses and to know, in broad terms, about their long-term management, both in respect of compliance problems, and the importance of teamwork, management skills and working in the community alongside primary care systems. Psychiatry provides a most useful and potentially well structured opportunity for medical students to experience working in the community. Medical students also especially need to know in a thorough way about the protean expressions of depression and how to assess suicide risk. However, other subject areas are equally important for the medical student, and psychiatry is often turned to as a discipline that might be able to contribute to and take the lead in such teaching. One such area which psychiatrists themselves have a variety of views about their competence to spearhead in this way is 'communication skills'.

Now that the GMC Education Committee is sharpening up its expectations that medical student education will develop quickly along the lines that it has long been advocating (GMC 1980, 1991), our discipline has an opportunity to re-evaluate its potential contributions, both in 'core' and 'selective' terms.

The following educational goals reflect our present departmental teaching aims within the St George's Hospital Medical School undergraduate curriculum. They have been developed by us over the last 20 years. They are submitted here as one of presumably many such versions that have developed up and down the country, and which might collectively now be useful as a starting point for change.

Knowledge

Basic knowledge of:

(a) the range of core psychiatric illness in adults, their recognition, classification, incidence and prevalence, natural histories and factors affecting them in their acute and chronic forms
(b) the range of core psychiatric illnesses in the elderly with particular reference to the special impact of dementing processes, the assessment and management of

confusional states, and the social and psychological strains of old age

(c) the range of core psychiatric illnesses and behavioural and emotional developmental problems that find expression in childhood and adolescence; also the special role of social and family factors in such pathology

(d) the range of other 'psychiatric morbidity', especially the wide range of the less florid depressive and anxiety disorders, and especially as they commonly exist within the community and present and are managed both within psychiatric services, other secondary care settings, general practice and other primary healthcare settings

(e) the nature of suicide and strategies to prevent it

(f) the particular communication and emotional problems associated with disabilities such as brain damage, deafness, loss of other body structure and function and chronic physical illness; also the ways in which superimposed learning difficulties complicate mental health and illness at all ages

(g) the concept of personality disorder and its clinical and forensic expressions (including the assessment of violence and dangerousness)

(h) the interface between psychiatry and the law – particularly the management of related psychiatric emergencies

(i) the range of disorders presenting with drug, alcohol, tobacco and other substance use; the concept of dependence, including physical, psychological and social dimensions; the presentation of addictive behaviour in the context of other illness, with consideration of the general principles underlying management, including negotiation of goals and minimisation of harm

(j) laws and regulations relating to the prescribing of controlled drugs

(k) the range of disorders of eating, sleeping and sexual experience and behaviours, presenting as such and determined to a greater or less extent by specific psychopathology and/or as part of psychiatric disorder itself

(l) the role of psychopathology in medical disorders and disturbed behaviours that present to other medical services

(m) theories concerning social, family, intrapsychic and chemical bases of psychopathology, psychiatric illness and the other disorders referred to above. The concept of multifactorial aetiology; interaction between genetic factors, past developmental and more immediate life experiences, including the impact of abuse, trauma, and the contribution of major life cycle events such as puberty, childbirth, child rearing and living with children or adolescents, loss of parents and others, onset of disability, involution

(n) the ethical issues which are specific to psychiatry and their relationship to the general ethical issues of medicine, in particular the issues concerning consent to examination and to treatment

(o) basic principles of pharmacological treatments of major and minor mental illnesses

(p) the legal requirements of the Mental Health Act that make admission possible whether the consultation is in hospital or the community and in psychiatric or non-psychiatric settings

(q) basic principles of other physical methods of treatment of major and minor mental illnesses

(r) basic principles and methods of interpersonal and behavioural psychotherapies and counselling in the treatment of major and minor mental illness

(s) primary preventive and rehabilitative approaches (e.g. to pathological responses to loss, risk behaviours such as smoking, excessive eating, promiscuity, institutionalisation)

(t) care of the long-term mentally ill: quality of life issues; compliance; the implications for carers of living with a mentally ill or learning disabled relative, etc.

(u) the role of other professionals/agencies: nursing staff, including community psychiatric nurses; social workers; psychologists; occupational therapists; self-help organisations; counselling services; and the strategies for working together with them in a team

(v) historical aspects of mental health and changing patterns of care.

Skills

The continued development of basic consultation skills with emphasis on the psychiatric setting and including:

(a) the communication skills relevant to medical practice and care, particularly including the abilities to communicate professionally with people of all ages, those with learning disabilities (and their families) and those from other ethnic groups. Also the ability to identify high risk situations such as suicidal

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intent, child abuse or dangerousness. Specifically, the student should:

(i) learn to take a formal 'psychiatric' history including the ability to incorporate information into it from other sources
(ii) be able to take a drug and alcohol history
(iii) develop the basic ability to examine all dimensions of the mental state. This skill needs to be developed to the same basic level as the medical student's competence in examining other systems within the body and with the expectation that thereafter it will be regularly used in the assessment of all patients
iv) be expected to have developed a basic understanding of the strong emotional relationship that often exists between patient and doctor, especially within the realm of psychiatric illness, and have the competence to use this to facilitate good communication in the interest of the patient
(v) be able to engage, examine and negotiate treatment approaches with a frightened and/or resistant patient in non-psychiatric settings who may be able to benefit from treatment if, and only if, their mental state is suitably examined and understood
(vi) be able to engage and examine a patient whose mental state is such that compulsory admission under the provisions of the Mental Health Act may be necessary for the protection of the patient or of others
(vii) be able to undertake these tasks within the community as well as hospital settings
(viii) be able to offer basic behavioural and relationship based psychotherapy under supervision

(b) Problem-solving skills (which underwrite the organisation of clinical and other investigatively derived information, the harnessing of background medical knowledge and the processes of differential diagnosis and the testing of consequent clinical hypotheses by further investigations and/or treatments). Specifically, the student is expected to develop the basic competence to be able to justify a diagnosis or differential diagnosis, complemented by a case formulation and management plan.

Attitudes

The continued development of the student's:

(a) ability to empathise with suffering at all stages of life and all levels of intelligence, even when it is not associated with help-seeking behaviour
(b) pursuit of high standards of professional practice both within hospital and community settings
(c) openness and willingness to address professionally the variety of ethical matters impinging on the practice of psychiatry
(d) interest in the 'psychiatric' approach to health and disease
(e) willingness to consider psychological and physical aspects of medical disorder without selectively ignoring either
(f) respect for the views of patients, other carers and colleagues, and a willingness to incorporate them into negotiations about treatment and management.

Acknowledgement

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References

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